MINUTES

JOINT LEGISLATIVE OVERSIGHT COMMITTEE ON MENTAL HEALTH, DEVELOPMENTAL DISABILITIES AND SUBSTANCE ABUSE SERVICES

October 16, 2008
Room 643, Legislative Office Building

The Joint Legislative Oversight Committee on Mental Health, Developmental Disabilities and Substance Abuse Services (LOC) met on Thursday, October 16, 2008 in Room 643 of the Legislative Office Building. Members present were Senator Martin Nesbitt, Co-Chair; Representative Verla Insko, Co-Chair; Senators Austin Allran, Bob Atwater, Charlie Dannelly, Jim Forrester, and William Purcell and Representatives Jeff Barnhart, Beverly Earle, Bob England, Jean Farmer-Butterfield, and Fred Steen. Advisory members Senator Larry Shaw, Representatives Van Braxton and William Brisson were also present.

Denise Harb, Shawn Parker, Ben Popkin, Gann Watson, and Rennie Hobby provided staff support to the meeting. Attached is the Visitor Registration Sheet that is made a part of the minutes. (See Attachment No. 1)

Representative Verla Insko, Co-Chair, called the meeting to order and welcomed members and guests. She asked for a motion to approve the minutes from the September 25, 2008 meeting. The motion was made and the minutes were approved. Representative Insko announced that since the October LOC meeting had been moved up one week, the monthly MH/DD/SA System Indicators Report was not available and would be mailed to members.

Representative Insko asked Dr. Hunter Thompson, Medical/Clinical Director, and Charlene Allen, Finance Officer of the Albemarle Mental Health Center (AMHC) to address the committee. Dr. Thompson expressed his concern over the failed reform efforts by the State. (See Attachment No. 2) He said that AMHC's catchment area is 10 a county region with some of the poorest and most rural areas in the State. He said that professionals have struggled to provide services in an environment which has forced them to choose who to see and who to deny services to due to a lack of resources. Dr. Thompson blamed the Division of MH/DD/SAS for the chaotic state of the system, and the funding problems for much needed services.

To address some of the problems, AMHC developed a partnership with the local hospital in Elizabeth City, and established a dedicated crisis unit with a Telemedicine service which allows doctors 24/7 assessments to all regions of the catchment area which includes 3,600 square miles. Other counties have requested to become part of the AMHC crisis service. Dr. Thompson explained AMHC's approach to involuntary commitment which he believes is more efficient, reduces redundancy and cost, and is responsible for cutting AMHC's State hospital admissions by nearly half. He stated that a grant had been submitted to the Kate B. Reynolds Foundation to place off duty officers in Albemarle

Hospital's crisis unit to reduce the impact on law enforcement agencies. The grant would allow officers on duty to return to the community while still providing security for the person to be admitted. The grant would also expand mental health services to the jails in the region with a funded jail coordinator position. The jail diversion program would provide an alternative for people unnecessarily incarcerated due to their mental health problems. If successful, AMHC hopes that the State would fund the program in the future. Dr. Thompson said that due to concern for patient care at Cherry hospital, AMHC had approached a regional hospital to establish a novel system to provide psychiatric coverage for their patients via telemedicine using the hospital's inpatient beds. The project would require the Division's approval and funding.

Dr. Thompson stated that AMHC was being forced to cut services due to the lack of funding for outpatient services. He said that being forced to discontinue services would have an impact on admissions to State hospitals, unnecessary use of courts and jails, congestion in emergency rooms, and would strain families and individuals desperate for help. Not all patients can be treated on a fee for service/privatization basis. In closing, Dr. Thompson stated that services could not be continued unless the State changed direction and provided public funding for clinical outpatient MH/DD/SA services. He said that freedom was needed to provide publicly-funded outpatient and crisis services to those unable to be treated by private practice. Other needs included: support of the 23-hour crisis center without restrictive funding; a community-based safety net treatment system via publicly-funded clinics; funding for serious core professional outpatient services; for the State to stop sending prepackage service products; and allow funding for professionals to provide the needed level and amount of services required for patients. Dr. Thompson was asked to provide, in writing, specific problems and solutions to mental health reform.

Members of the committee agreed that one of the biggest challenges was addressing services in rural areas. It was suggested that public providers may be the answer; in addition, that the funds appropriated in last year's budget for local inpatient capacity would also help. Charlie Franklin, Director of the AMHC said that they had requested some of the funds from the $6 million but because the 23-hour crisis unit reduced in half the admissions at Cherry hospital, Albemarle was told in a memo that AMHC would not receive any money since they were not over utilizing the State mental health institutions. Leza Wainwright, Co-Director of the Division on MHDDSAS, stated that she was not aware of any communication from the Division of any unwillingness to allocate any of the new inpatient dollars if inpatient hospital beds can be created in the Albemarle catchment area. The dollars appropriated from the General Assembly are for the creation and incentivization of new inpatient beds. She indicated that the Division would be happy to discuss the possibility with AMHC. She said that the Division was currently in negotiations with 5 hospitals across the State but that none of the 200 beds allocated were operational yet. Ms. Wainwright also said that in trying to prioritize where to boost inpatient beds, the Division looked at the 4 LMEs in each of the 3 hospital regions that had the highest utilization of the State hospital beds for 7 days or less length of stay. Albemarle was not one of the top four. Members wanted to be sure that LMEs were not punished for not using State hospitals. It was stated that it was important to see that the

beds were distributed across the State in areas where there are none, and as the money comes in, in the future, see that everyone gets their share.

Next, Charlene Allen, Finance Officer for AMHC, said the budget for Albemarle was $19.8 million and currently had $6 million in unit cost reimbursement dollars. She said that there were 190,000 people in the 10 county catchment area, with 250,000 people during the tourist season. There are 6,000 cases divided between approximately 120 providers. She said that it calculated to be about $1,000 a year per consumer or $85 per month to provide services for 6,000 consumers. Ms. Allen said that $10 million was needed to cover the costs associated with LME authorizations, and provider and service needs. A request has been submitted to the Division for $4 million in additional funds. Over the last 2 years Albemarle has contributed a portion of their fund balance ($4.9 million) to the budget to pay for services to the indigent population, and to spread out services to the providers. Ms. Allen said that AMHC could no longer do this and maintain their financial integrity.

Dr. Janis Nutt, Area Director of the Johnston LME, addressed the successes and challenges in Johnston County in the time of mental health reform. (See Attachment No. 3) Dr. Nutt gave a brief history and reviewed the 5 basic services provided. She explained how strong community collaborations and partnerships had contributed to the strength of the LME. Dr. Nutt explained the functions of the Access Team and the care in following State policy in endorsement and monitoring to ensure standardization regarding provider relations. She said they worked diligently with providers to improve the quality of their services, and has a dedicated staff that does provider education and training. Dr. Nutt said that an exciting new project had begun in a partnering with Johnston Memorial Hospital for a 4 bed observation/crisis stabilization unit. Many consumers are discharged within 24 hours. Some of the challenges mentioned were: That standardization does not always work and that the system needs flexibility in implementation; that there is a place in the public sector for service revision for the more seriously mentally ill with complex needs; that the system must determine how to move forward while recognizing that many of the functions done by an LME are best done in the local communities and others, like Utilization Review for Johnston, should be performed by partners.

Staff was requested to provide a chart with an overview of the LMEs showing the total population of each catchment area, the number served, the total budget, the number of months operated in fund balance, indicating which LMEs are above or below the 8% fund balance, and provide the top 5 salaries for each LME.

Next, Dr. Shealy Thompson, Quality Management Team Leader for the Division of MH/DD/SAS, provided a matrix of a summary of the LME performance measures that are tracked on a regular basis in the Community Systems Progress Report. (See Attachment No. 4) She described that the top banner indicated the 21 performance measures required in the contract between the Department and each LME for indicators of quality care. She said the measures were national measures that included: block grant measures for the Federal block grant dollars for mental health and substance abuse; some are Healthcare Effectiveness Data Information Set (HEDIS) measures used by most

health plans in the country to measure quality care; and some are developed by the Washington Circle of Public Sector Workgroup – national substance abuse experts. Dr. Thompson said the 3 areas that should be below the standard indicated were: Effective use of State psychiatric hospitals; Readmissions; and Child services in non-family settings. She also pointed out that the green numbers highlighted indicated where the State or an LME had exceeded the standard. Dr. Thompson added that the State had met the standards for 18 of the 21 measures. It was recommended that committee members take time to review the very thorough information provided in the matrix.

Dr. Jim Osberg, Chief of State Operated Services provided an update on the State ADATC facilities, and on the State psychiatric hospitals. Beginning with the Julian F. Keith ADATC, he said that the construction of the 30 bed acute unit was nearly complete with patients expected to move in on November 3. He said that by the second week in December there should be 30 acute and 50 sub-acute beds. There will also be pharmacy service by January 1. At Walter B. Jones, he said that a connector building between dorms would be ready by November 1, and that capacity would be up to 80 beds with 24 acute and 56 sub-acute beds. He added that there had been an increase in utilization of the acute beds. Dr. Osberg said that R.J. Blackley had been a part of Umstead hospital and more recently under Central Regional hospital. He said that policies and procedures had been finalized and were they working on staffing for Blackley to become an ADATC. He said the facility would be ready in November with 50 beds but the target was to eventually have an 80 bed capacity. Dr. Osberg also said that the Barrett Building on Umstead was to undergo renovation for an ADATC unit which would be completed in August, 2009.

Regarding an update on the State hospitals, Dr. Osberg said that Cherry hospital had received decertification from the Centers for Medicaid and Medicare Services (CMS). He said the Department was working on addressing the issues identified in the survey in order to reapply in the future. The Compass Group, a hospital consulting group, provided a review of facility operations which has become a public document. He said several issues in the report would be addressed prior to reapplying for certification. Negotiations are underway to have the Compass Group provide consultation on moving forward with changes needed for Cherry hospital. Dr. Osberg added that Joint Commission had been to Cherry hospital to survey, and the Department was currently waiting for the letter regarding accreditation. Addressing the nursing issue, Dr. Osberg said that the hospitals were trying to be competitive with other hospitals but often other hospitals offered incentives like sign-on bonuses. However, the expansion budget this year allotted $500,000 to implement sign-on bonuses which would allow potentially 60-70 new nurses. He was also asked what the retention rate was and he responded that he would get the information back to the committee. Members addressed the fact that reducing the population at the hospitals would impact the patient to staff ratio.

Dr. Osberg said that Central Regional Hospital (CRH) now included the Butner campus and the Dix campus. The Division of Health Services Regulations (DHSR), the State agency for CMS, found that CRH was not in compliance with 2 conditions of participation (medical staff and governing body) for certification. There must be 1

organized medical staff with 1 provider number. CRH is now operating under 1 organized medical staff and 1 management staff for both locations. There will be a resurvey by CMS in November.

Leza Wainwright, Co-Director of the Division on MHDDSAS, gave a snapshot on the changes with Community Support for Medicaid and State funded services relative to people and the numbers of services being received. (See Attachment No. 5) Responding to a question regarding expenditures, Ms. Tara Larson, Acting Director of the Division of Medical Assistance (DMA), told members that expenditures for the first quarter this year were down to $139 million compared to the first quarter last year of $262 million, a difference of 47%. She said she would provide a handout of those figures. She said that DMA was tracking Medicaid expenditures on people served as well as other services being received by check write each month

Representative Insko recognized Judge Julian Mann, Office of Administrative Hearings (OAH), who was present to address any questions regarding the appeals process. She then asked Ms. Larson to give an update on the appeals process. Ms. Larson first explained that the Legislature changed two processes, Community Supports for provider appeals, and for recipient appeals. Previously, Community Supports provider appeals could appeal to the DHHS hearing office level as well as going to OAH. Now, the appeals go to the Department hearing office under a different process, an evidentiary hearing. She said this process went into effect in July, 2008 and would sunset in July, 2010. Ms. Larson said that there were currently 200 provider appeals in process with the DHHS hearing office. The appeals transferred from OAH are beginning to be heard at the DHHS hearing office. She said that Medicaid recipient appeals have to be the same across the board since that is an entitlement for recipients. Ms. Larson stated that from July, 2007 to June, 2008 there were over 11,000 appeals, with over 9,000 in Community Supports. Legislation required that the cases be transferred from DHHS to OAH with most transfers occurring by October 1. As of October 1, there were 244 of the 9,000 cases that had not been resolved. She added that a formal mediation had been added as part of the hearing process at OAH. Legislation also changed the timeline making it a 90 day process.

After lunch, Valerie Bradley, President of Human Services Research Institute, presented a review, and gave recommendations from a stakeholders group in the Developmental Disabilities field concerned about the direction of the system. (See Attachment No. 6) The summit, sponsored by the N.C. Council on Developmental Disabilities, hoped to create a pragmatic agenda for the new administration regarding concrete steps that would enrich and expand services. She reviewed challenges facing other states as well as North Carolina such as the aging population, the growing waiting lists for home and community based services, and the need to strengthen case management. Ms. Bradley reviewed the visions of the demographic and economic realities, the infrastructure for individualized and valued services and supports, and ID/DD leadership, expertise and partnerships. She then focused on the targeted areas for each vision. The four areas of recommendation from the group included a viable workforce, quality management and quality improvement, case management, and fostering leadership and innovation. Regarding case

managers, Ms. Bradley suggested that the Division might convene a group of stakeholders, and providers along with DMA, and the LMEs, to look at what case managers should be doing and perhaps determine a new vision of what case management should do given the challenge of the rate cuts. It was also stressed that there be a larger critical mass of people who have an understanding of the waiver and of DD in the Division, and that there be a similar expertise at the LME level as they become managers of the service system. The salary level must be high enough to recruit people who have the adequate expertise to do the job.

Next, Leza Wainwright addressed the issue of family members providing CAP MR/DD services. She said the topic of family caregivers as paid providers of the CAP MR/DD waiver had been a topic of interest since October, 2006. Three primary concerns noted were: 1) the potential conflict of interest when the guardian who must sign the person centered plan (PCP) is also the paid caregiver; 2) potential for inadequate monitoring; and 3) in the area of quality assurance, concern over a single individual providing 50, 60, over 100 hours of service every week – is the consumer receiving proper services? Ms. Wainwright said that the Department looked at 7 other states and found that the policy in North Carolina was very liberal compared to others.

Ms. Wainwright was asked how many family members were delivering services, and she responded that the information was noted on the (PCP) but was not a field captured in the database. Originally, the Department's policy stated that a family member living at home with a consumer would have been limited to 50 hours a week, and family members living external to the consumer could also provide 50 hours of service. As part of the development of the new waiver, the Department decided to revisit the issue. After several stakeholder meetings, a recommendation from family members, suggested that a specific service definition for parents or guardians who live with the consumer as the paid caregiver be developed, thus the Home Supports definition, which should go into effect with the implementation of the new waiver on November 1, pending approval. She said there were 4 levels based on the intensity of need, paid at a daily rate. (The daily rates have not been finalized.) Ms. Wainwright said that the original direction stated a family had to provide all of the Home Supports but a recent change states since it is paid on a daily rate on any day that the family provides the services in the home they will have to provide 100% of the services for that day. If a family decides to provide services on Monday, Wednesday, and Friday, they can have someone from the outside provide services on Tuesday, Thursday, and Saturday. She said that Home Supports was not tied to the hour but rather to the intensity of service the person needs. She emphasized that the Home Supports service definition was for services delivered within the home. That same individual is still eligible to receive other services under the waiver that are not delivered in the home. Ms. Wainwright said that this was the preferred alternative from the stakeholders with whom the Department interacted. Many families voiced concern over the fact that there was no one to come in and provide services. She said that there were respite services available for families who chose to provide Home Supports and do the majority of the service. The respite service is in addition to the daily rate. She added that there were no limitations on any family member who does not live with the consumer regarding the hours of service that they can deliver. There was much discussion among

members regarding the inability of family members to share the service provision with someone of their choice. Members learned that Home Supports was written into the waiver, thus the committee would not be able to change the language. Representative Insko suggested that further questions and concerns be directed to staff.

The last presenter, Cynthia Vester from the NC Consumer, Advocacy, Networking and Support Organization (NC-CANSO), reported that NC-CANSO was established as a result of legislation (H.B. 1888) for the purpose of establishing an independent statewide organization formulated to facilitate communication and support among people with MH/DD/SA issues. Ms. Vester reviewed accomplishments during the past year and respectfully requested additional funding in the next session to continue the process of forming as an independent entity.

There being no further business, the meeting adjourned at 3:25 PM.

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Senator Martin Nesbitt, Co-Chair Representative Verla Insko, Co-Chair

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Rennie Hobby, Committee Assistant